PATIENT REGISTRATION FORM

Last Name:_______________________________Address:_________________________________
First Name:_______________________________City:_________State: Zip Code___________
Home Phone # ( )______________Cell Phone # ( )______________Work#( )____________
Race___________Language___________Hispanic (Yes) (No) DOB:______/ _ / _ Age: Sex:
Marital Status: ____________________
Employer:____(Full Time)(Part Time)
E-mail Address:____

Primary Pharmacy: Name/City____

PRIMARY INSURANCE

Insurance Name:________________________________Address:____________________________
Policy/Group #:________________________________City:_______________________State:
Insured's ID#:_____________________________Zip Code:__________Phone#: ( )___________

SUBSCRIBERS INFORMATION

Last Name:______________________________First Name__________________________________
DOB_________Address:______________________City:_______________________State:
Insured's ID#:____________________Zip Code:_________Phone#: ( )____________________

SECONDARY INSURANCE

Insurance Name:________________________________Address:____________________________
Policy/Group #:________________________________City:_______________________State:
Insured's ID#:_____________________________Zip Code:__________Phone#: ( )___________

SUBSCRIBERS INFORMATION

Last Name:______________________________First Name__________________________________
DOB_________Address:______________________City:_______________________State:
Insured's ID#:____________________Zip Code:_________Phone#: ( )____________________

EMERGENCY CONTACT:

Last Name:_____________________First:__________________MI:_____Relationship:____________
Address:____
____

Home Phone: ( ) ________________________ Cell ( ) _________________________________

Alt Phone ( )_________________________Work ( )__________________________________

I have read and answered all questions to the best of my knowledge. I understand that the charges incurred are my responsibility regardless of insurance coverage. *Diablo Valley Primary Care, Inc*. has provided me the opportunity to review and/or have a personal copy of their Notice of Privacy Practices. I understand that it is my responsibility to inform this office of any changes in the above information.

____ ___________________________

Signature of Patient/Subscriber **Date**

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I further expressly agree that this signature will bind me as though I had personally signed the particular claim.

I,_________________________hereby authorize________________________
(Subscriber/Patient) (Insurance Carrier)

to pay and hereby assign directly to **Diablo Valley Primary Care** all benefits, if any, otherwise payable to me for services described on the attached form. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Diablo Valley Primary Care** will be credited to my account, in accordance with the above said agreement.

"NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov"

____ ____________
Authorized Signature of Subscriber/Patient **Date**

COMMUNICATION PREFERENCES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐**Home Telephone**_________________________

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

Written Communication

☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address

☐**Cell Phone**________________________

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

Please List one: Family/Personal Contact __________________
____

☐**Work Telephone** ___________________

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

____ ______________
Patient/Guardian (print and signature) **Date**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for treatment, payment or healthcare operations may be permitted without prior consent in an emergency.

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient's Name:____Date of Birth:______/____/_______

Telephone # (_____)____

INFORMATION TO BE RELEASED FROM:

I hereby authorize Dr./ NP ____

____
ADDRESS **CITY** **STATE** **ZIP CODE**

to release the following medical information contained in the patient's medical record.

INFORMATION TO BE RELEASED TO:

Diablo Valley Primary Care Inc.
Chinnavuth De Monteiro, MD P
Ashley Greer, PA-C
Claire Reiton, PA-C 2415
High School Ave. Suite 800
Concord, CA. 94520
925-687-5210 (phone)

TYPE OF INFORMATION TO BE RELEASED
PLEASE DO NOT FAX RECORD IF ITS MORE THAN 10 PAGES, PLEASE MAIL TO THE ADDRESS ABOVE

CHECK ALL BOXES ACCEPTABLE TO RELEASE

1. **GENERAL RELEASE**
   - ❑ ALL RECORDS From:___________________To:______________________
   - ❑ Medical Records excluding protected records From:___________________To: ______________________
   - ❑ Test Results (specify) _____________ From:___________________To:_____________ _________
   - ❑ Records pertaining to specific medical date; (i.e. Motor Vehicle Accident, Immunizations) Specify:____
2. **INFORMATION PROTECTED BY STATE/FEDERAL LAW NOT TO BE DISCLOSED**
   - ❑ Sexually Transmitted Disease From:_________________To: ______________________
   - ❑ Diagnosis/Treatment or counseling (includes HIV/AIDS)
   - ❑ Drug Abuse/Alcoholism Diagnosis/Treatment From:_________________To: ______________________
   - ❑ Mental Health Diagnosis/Treatment From:_________________To: ______________________

1. **INSURANCE COMPANY REQUESTING A COPY OF YOUR MEDICAL RECORD**
   Please be advised that your Life/Health/Disability insurance company has contacted this office to release your medical record in its entirety. By complying with this request you are forfeiting the confidentiality of your Protected Health Information (PHI). You are allowing the release of personal notes, examination findings, diagnosis, test results and treatment plans. Please understand that by releasing this information you may suffer the loss of coverage entirely. These ramifications are based on subjective interpretation of finding in your medical record and compared to your insurance company's actuarial data. As a result, the insurance company's interpretation of your overall health may not always coincide with my overall opinion of your medical health.

____ ___________/_________/____________
PATIENT SIGNATURE (or Legal Representative) **DATE**

Limiting your authorized release may lead to minor delay in mailing records. Some records may include both protected and unprotected information, therefore; exclusions may create an incomplete document. This authorization applies ONLY to this request. Future requests will require another signed form. All requests will require 14 days for completion.

PERSONAL MEDICAL INFORMATION

NAME:____DATE: ____________________

Occupation:____How Long? _________________

Your living situation?______Alone______Couple______Group

Do you have or live with children?______Yes______No. If yes please give gender and ages ______________________

Do you have any allergies or reactions to medications? (Please explain) ____________________________________
____

Do you have a special diet or health practices? (Please explain) ____
____

Do you do any form of exercise, play sports or have any special interests? _________________________________
____

When was your last complete physical examination? _____ years _____ months

When was your last dental examination? _____ years _____ months

When was your last eye examination? _____ years _____ months

When was your last cholesterol check? _____ years _____ months

Do you smoke? _____ yes _____ no If yes, For how long and how much per day/week? _______________________

Do you drink alcohol? _____ yes _____ no. If Yes, How much and how often? ______________________________

Do you drink coffee? _____ yes _____ no. If Yes, How much and how often? _______________________________

Have you ever had a problem with alcohol or drugs? ___ Yes ___ No If Yes please explain: ____________________
____

What is the purpose of this visit? ____
____

TESTS AND IMMUNIZATIONS: (If you have had any of the following, please enter the year.)

Gall Bladder X-ray	___________	Last TB Test	__________
Chest X-ray	___________	Last Tetanus Shot	__________
GI Series	___________	Last Measles Vaccination	___________
Kidney X-ray	___________	Electrocardiogram	___________

Are you up to date with all your immunizations?_____Yes_____No_____Don't know

Please list any other tests or immunizations not mentioned here**:** ____
____
____
____

Health History

Has anyone in your family had any of the following? **(Please include yourself)**

High Blood Pressure ____________________
Heart Trouble ____________________
Stroke ____________________
Migraines ____________________
Emotional Problems (Treated) ____________________
Arthritis/Rheumatism____________________
Tuberculosis ____________________
Anemia ____________________
Diabetes ____________________
Seizures ____________________
Glaucoma ____________________
Alcoholism ____________________
Breast Cancer ____________________
Cancer (What kind) ____________________
Other inherited diseases not listed: ____________________

Please indicate the present health of your family members:

Father	Good	Poor	Deceased (Age and Cause) ____________________
Mother	Good	Poor	Deceased (Age and Cause) ____________________
Brother/Sister	Good	Poor	Deceased (Age and Cause) ____________________
Brother/Sister	Good	Poor	Deceased (Age and Cause) ____________________
Brother/Sister	Good	Poor	Deceased (Age and Cause) ____________________

If there are any other family members not mentioned above and there is any information you think is important about their health, Please add them below: ____________________
____
____

Please check additional illnesses or problems that you have had:

____Measles	____Mononucleosis	____Bronchitis	____Hernia
____Mumps	____Syphilis	____Pneumonia	____Hemorrhoids
____Scarlet fever	____Hepatitis	____Eczema	____Eye problems
____Polio	____Malaria	____Liver disease	____Stomach problems
____Rheumatic fever	____Rashes/Hives	____Thyroid	____Gall bladder problems

If you have ever been hospitalized for a serious illness or operation, or if you had a serious illness without being hospitalized please list them below. (Illness, operation, and date) ____________________
____
____
____
____

Please list any medications that you are currently taking. Include all non-prescription drugs, like aspirin, laxatives, antacids and vitamins: ____________________
____
____
____
____
____
____
____

GYNECOLOGY HISTORY

NAME____DATE ________________

At what age did you have your first period?______Years

Are your periods regular?____yes____no. How many days do you have between periods? ____________

How many day do your periods last?______. Is the bleeding heavy?_____yes_____no

Do you have any problems with pain or cramping during your period?_____yes___no

Do you feel tense or unhappy during your period?_____yes_____no

Do you douche?_____yes_____no With what? ____

Do you have a discharge from your vagina today?_____yes_____no

Please describe it ____

Have you ever been pregnant? Yes____no____How many children do you have? ____________________

Have you ever had an abortion? yes____no____How many? _____________________________________

Have you ever had a miscarriage? Yes____no____How many? __________________________________

Did you have any problems with pregnancy, delivery or abortion? (please describe) ___________________

CONTRACEPTIVE HISTORY: Are you sexually active with men____women____or both____?

Do you use birth control? Yes____no____What type of birth control do you use? ____________________

Have you ever used any other type of birth control? (please describe) _______________________________

Do you ever have pain with intercourse? Yes____no ____

Have you ever been treated for:
Problems with your uterus: (fibroids, abnormal pap smear, vaginal bleeding, etc.
Please describe) ____
STD? (please explain) ____

Do you examine your breasts yes____no ____

Date of last pap smear __________________

Date of last pelvic exam _________________

Date of last breast exam _________________

<u>THIS INFORMATION WILL REMAIN CONFIDENTIAL</u>

Authorization to Disclose and Release Information

In this office we feel as though all aspects of healthcare is confidential between the patient, their Doctor and the office.

We understand some patients would like their family, friends, caretaker's etc. to be involved in their healthcare management. In an effort to protect your personal information we ask that all patients over the age of 18, that would like their healthcare information shared to please sign and check what information you authorize us to release on your behalf.

We thank you in advance as this helps us to provide the best quality healthcare possible.

I ________________________________ give authorization to ________________________,
Patient Name **Appointed Person(s) Name**

__________________________________, ______________________________________,

__________________________________,
to do the following on behalf of my medical care:

- ❑ Schedule, cancel and verify appointments.
- ❑ Inquire about lab and x-ray results
- ❑ Request prescription refills
- ❑ Speak to the doctor about my healthcare
- ❑ Other ____

If this authorization is temporary please indicated the date in which this authorization is no longer valid.

______________________________.
Date

________________________________ ______________________
Signature of Patient **Date**